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Division of Administration
Office of Group Benefits

Public Hearing – Substantive Changes to Proposed Rule
Employee Benefits
(LAC 32:I.319, 323, 1109; LAC 32:III.105, 107, 109; and LAC 32:V.203, 205, 207, 305, 307, 405, 505, 507)

In accordance with the applicable provisions of R.S. 49:950, et seq., the Administrative Procedure Act, the Office of Group Benefits published a Notice of Intent in the May 20, 2017, edition of the *Louisiana Register* to implement several changes to the Office of Group Benefits rules. Office of Group Benefits received written comments on the proposed rulemaking and facilitated a public hearing on June 28, 2017, to receive comments and testimony on the proposed Rule. After a thorough review and careful consideration of the comments and testimony received on the Notice of Intent, the Office of Group Benefits has decided not to pursue at this time the provisions of the original proposed Rule regarding the implementation of tobacco and spousal surcharges (proposed LAC 32:I.510) or the revisions to LAC 32:I.315. Office of Group Benefits will proceed with the remainder of the proposed rulemaking with no changes, as set forth below. These actions will enhance member clarification and provide for the administration, operation, and management of health care benefits effectively for the program and member. The fiscal and economic impacts of the remaining portions of the Notice of Intent have been sent to the Legislative Fiscal Office for evaluation.

Title 32
EMPLOYEE BENEFITS
Part I. General Provisions

Chapter 3. Uniform Provisions—Participation in the Office of Group Benefits

§319. Continued Coverage

A. - C.4. ...

D. Over-Age Dependents. If a dependent child who is the natural or adopted child of the enrollee is incapable of self-sustaining employment by reason of mental or physical incapacity and became incapable prior to attainment of age 26, the coverage for that dependent child may be continued for the duration of incapacity.

D.1. - E.3.b. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:341 (February 2015), effective March 1, 2015, amended LR 43:

§323. Employer Responsibility

A. ...

B. A participating employer shall immediately inform OGB when a retiree with OGB coverage returns to benefit-eligible employment. The enrollee shall be placed in the re-employed retiree category for premium calculation. The re-employed retiree premium classification applies to retirees with and without Medicare. The premium rates applicable to the re-employed retiree premium classification shall be identical to the premium rates applicable to the classification for retirees without Medicare. If the re-employed retiree suspends retirement benefits and returns to benefit-eligible employment with the agency from which the re-employed retiree originally retired, the employee portion of the premium shall be withheld by payroll deduction and the employing agency shall remain responsible for the employer portion of the premium. If the re-employed retiree suspends retirement benefits and returns to benefit-eligible employment with an OGB participating agency other than the agency from which the re-employed retiree originally retired, the employee portion of the premium shall be withheld by payroll deduction, and the employing agency shall be responsible for the employer portion of the premium throughout the duration of employment. If the re-employed retiree returns to benefit-eligible employment, yet does not suspend retirement benefits as allowed by law, the employee portion of the premium shall be withheld by payroll deduction, and the employing OGB participating agency shall be responsible for the employer portion of the premium throughout the duration of employment. When the re-employed retiree separates from employment with the OGB participating employer, the employer shall notify OGB of such separation within 30 days. After the re-employed retiree again separates from employment with an OGB participating employer, the agency from which the re-employed retiree originally retired shall again be responsible for the employer portion of the premium.

C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:345 (February 2015), effective March 1, 2015, amended LR 41:2351 (November 2015), effective January 1, 2016, amended LR 43:

Chapter 11. Contributions

§1109. Retirees with Medicare Parts A and B

A. Employees who retire on or after July 1, 1997, and who are not rehired retirees in a benefit-eligible position, shall receive a reduced premium rate when enrolled in Medicare Parts A and B.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 24:496 (March 1998), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:350 (February 2015), effective March 1, 2015, amended LR 43:

Part III. Primary Plan of Benefits

Chapter 1. Operation of Primary Plan

§105. Out of Pocket Maximums

Out-of-Pocket Maximum Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
Individual:	**Network**	**Non-Network**
Active Employee/Retirees on or after March 1, 2015	$3,500	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	$2,000	No Coverage
Individual, Plus One Dependent:		
Active Employee/Retirees on or after March 1, 2015	$6,000	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	$3,000	No Coverage
Individual, Plus Two or More Dependents:		
Active Employee/Retirees on or after March 1, 2015	$8,500	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	$4,000	No Coverage

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:350 (February 2015), effective March 1, 2015, amended LR 43:

§107. Schedule of Benefits

A. Benefits, Copayments, and Coinsurance

	Copayments and Coinsurance	
	Network Providers	**Non-Network Providers**
Physician Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics	$25 Copayment per Visit	No Coverage
Allied Health/Other Professional Visits: • Chiropractors • Federally Funded Qualified Rural Health Clinics • Nurse Practitioners • Retail Health Clinics • Physician Assistants	$25 Copayment per Visit	No Coverage
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic	$50 Copayment per Visit	No Coverage
Ambulance Services – Ground (*for Emergency Medical Transportation only*)	$50 Copayment	$50 Copayment
Ambulance Services - Air (*for Emergency Medical Transportation only*) Non-Emergency requires prior authorization[2]	$250 Copayment	No Coverage
Ambulatory Surgical Center and Outpatient Surgical Facility	$100 Copayment	No Coverage
Birth Control Devices – Insertion and Removal (*as listed in the Preventive and Wellness Article in the Benefit Plan*)	100% - 0%	No Coverage
Cardiac Rehabilitation (*limit of 36 visits per Plan Year*)	$25/$50 Copayment per day depending on Provider Type[2] $50 Copayment - Outpatient Facility[2]	No Coverage
Chemotherapy/Radiation Therapy (*Authorization not required when performed in Physician's office*)	Office - $25 Copayment per Visit Outpatient Facility 100% - 0%[1,2]	No Coverage
Diabetes Treatment	80% - 20%[1]	No Coverage
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	$25 Copayment	No Coverage
Dialysis	100% - 0%[1]	No Coverage
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20%[1,2] of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year	No Coverage
Emergency Room (*Facility Charge*)	$200 Copayment; Waived if admitted to the same facility	
Emergency Medical Services (*Non-Facility Charges*)	100% - 0%[1]	100% - 0%[1]
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (*purchased within six months following cataract surgery*)	Eyeglass Frames – Limited to a Maximum Benefit of $50[1]	No Coverage
Flu shots and H1N1 vaccines (*administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair*)	100% - 0%	No Coverage
Hearing Aids (*Hearing Aids are not covered for individuals age eighteen (18) and older.*)	80% - 20%[1,3]	No Coverage
Hearing Impaired Interpreter Expense	100% - 0%	No Coverage
High-Tech Imaging – Outpatient • CT Scans • MRA/MRI • Nuclear Cardiology • PET Scans	$50 Copayment[2]	No Coverage
Home Health Care (*limit of 60 Visits per Plan Year*)	100% - 0%[1,2]	No Coverage
Hospice Care (*limit of 180 Days per Plan Year*)	100% - 0%[1,2]	No Coverage
Injections Received in a Physician's Office (*when no other health service is received*)	100% - 0%[1]	No Coverage
Inpatient Hospital Admission, All Inpatient Hospital Services Included	$100 Copayment per day[2], maximum of $300 per Admission	No Coverage
Inpatient and Outpatient Professional Services for Which a Copayment Is Not Applicable	100% - 0%[1]	No Coverage
Mastectomy Bras – Ortho-Mammary Surgical (*limited to three (3) per Plan Year*)	80% - 20%[1] of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year	No Coverage
Mental Health/Substance Abuse – Inpatient Treatment and Intensive Outpatient Programs	$100 Copayment per day[2], maximum of $300 per Admission	No Coverage
Mental Health/Substance Abuse – Office Visit and Outpatient Treatment (Other than Intensive Outpatient Programs)	$25 Copayment per Visit	No Coverage
Newborn – Sick, Services excluding Facility	100% - 0%[1]	No Coverage

	Copayments and Coinsurance	
	Network Providers	Non-Network Providers
Newborn – Sick, Facility	$100 Copayment per day[2], maximum of $300 per Admission	No Coverage
Oral Surgery	100% - 0%[1,2]	No Coverage
Pregnancy Care – Physician Services	$90 Copayment per pregnancy	No Coverage
Preventive Care – Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (*For a complete list of benefits, refer to the Preventive and Wellness Article in the Benefit Plan.*)	100% - 0%[3]	No Coverage
Rehabilitation Services – Outpatient: • Speech • Physical/Occupational (*Limited to 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.*) (*Visit limits do not apply when services are provided for Autism Spectrum Disorders.)*	$25 Copayment per Visit	No Coverage
Skilled Nursing Facility (*limit of 90 days per Plan Year*)	$100 Copayment per day[2], maximum of $300 per Admission	No Coverage
Sonograms and Ultrasounds (*Outpatient*)	$50 Copayment	No Coverage
Urgent Care Center	$50 Copayment	No Coverage
Vision Care (Non-Routine) Exam	$25/$50 Copayment depending on Provider Type	No Coverage
X-ray and Laboratory Services (*low-tech imaging*)	Hospital Facility 100%-0%[1] Office or Independent Lab 100%-0%	No Coverage
[1]Subject to Plan Year Deductible, if applicable [2]Pre-Authorization Required, if applicable. Not applicable for Medicare primary. [3]Age and/or Time Restrictions Apply		

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:350 (February 2015), effective March 1, 2015, amended LR 43:

§109. Prescription Drug Benefits

A. Prescription Drug Benefits

Network Pharmacy	Member pays
Tier 1- Generic	50% up to $30
Tier 2- Preferred	50% up to $55
Tier 3- Non-preferred	65% up to $80
Tier 4- Specialty	50% up to $80
90 day supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable copayment
Co-Payment after the Out Of Pocket Amount of $1,500 Is Met	
Tier 1- Generic	$0
Tier 2- Preferred	$20
Tier 3- Non-preferred	$40
Tier 4- Specialty	$40
Prescription drug benefits-31 day refill	
Plan pays balance of eligible expenses	
Diabetic supplies are not subject to a copayment if enrolled in the In-Health/Disease Management Program.	
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug; the cost difference does not apply to the $1,500 out of pocket maximum	
Medications available over-the-counter in the same prescribed strength are not covered under the pharmacy plan.	
Smoking Cessation Medications: Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.	
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.	

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:352 (February 2015), effective March 1, 2015, amended LR 43:

Part V. Additional Plans and Operations

Chapter 2. PPO Plan Structure - Magnolia Open Access Plan

§203. Out of Pocket Maximums

Includes All Eligible Copayments, Coinsurance Amounts and Deductibles					
	Active Employee/Retirees on or after March 1, 2015		Retirees prior to March 1, 2015 Without Medicare		Retirees prior to March 1, 2015 With Medicare
	Network	Non-Network	Network	Non-Network	Network and Non-Network
Individual Only	$3,500	$4,700	$2,300	$4,300	$3,300
Individual Plus One (Spouse or Child)	$6,000	$8,500	$3,600	$7,600	$5,600
Individual Plus Two	$8,500	$12,250	$4,900	$10,900	$7,900
Individual Plus Three	$8,500	$12,250	$5,900	$13,700	$9,900
Individual Plus Four	$8,500	$12,250	$6,900	$13,700	$11,900
Individual Plus Five	$8,500	$12,250	$7,900	$13,700	$13,700
Individual Plus Six	$8,500	$12,250	$8,900	$13,700	$13,700

Includes All Eligible Copayments, Coinsurance Amounts and Deductibles					
	Active Employee/Retirees on or after March 1, 2015		Retirees prior to March 1, 2015 Without Medicare		Retirees prior to March 1, 2015 With Medicare
	Network	Non-Network	Network	Non-Network	Network and Non-Network
Individual Plus Seven	$8,500	$12,250	$9,900	$13,700	$13,700
Individual Plus Eight	$8,500	$12,250	$10,900	$13,700	$13,700
Individual Plus Nine	$8,500	$12,250	$11,900	$13,700	$13,700
Individual Plus Ten	$8,500	$12,250	$12,900	$13,700	$13,700
Individual Plus Eleven or More	$8,500	$12,250	$13,700	$13,700	$13,700

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:355 (February 2015), effective March 1, 2015, amended LR 43:

§205. Schedule of Benefits

A. Benefits and Coinsurance

	Coinsurance		
	Active Employees/ Non-Medicare Retirees (regardless of retire date)		Retirees with Medicare (regardless of retire date)
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Physician Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Allied Health/Other Professional Visits: • Chiropractors • Federally Funded Qualified Rural Health Clinics • Nurse Practitioners • Retail Health Clinics • Physician Assistants	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Specialist (Physician) Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Ambulance Services - Ground (*for Emergency Medical Transportation only*)	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Ambulance Services - Air (*for Emergency Medical Transportation only*) Non-emergency requires prior authorization[2]	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Ambulatory Surgical Center and Outpatient Surgical Facility	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Birth Control Devices - Insertion and Removal (*as listed in the Preventive and Wellness Care Article in the Benefit Plan)*	100% - 0%	70% - 30%[1]	Network Providers 100% - 0% Non-Network Providers 80% - 20%[1]
Cardiac Rehabilitation (*limit of 36 visits per Plan Year)*	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[12]
Chemotherapy/Radiation Therapy (Authorization not required when performed in Physician's office)	90% - 10%[1, 2]	70% - 30%[1, 2]	80% - 20%[1,2]
Diabetes Treatment	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	90% - 10%[1]	Not Covered	80% - 20%[1]

	Coinsurance		
	Active Employees/ Non-Medicare Retirees (regardless of retire date)		Retirees with Medicare (regardless of retire date)
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Dialysis	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1,2]
Emergency Room (*Facility Charge*)	$150 Copayment[1]; Waived if admitted to the same facility		
Emergency Medical Services (*Non-Facility Charges*)	90% - 10%[1]	90% - 10%[1]	80% - 20%[1]
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (*purchased within six months following cataract surgery*)	Eyeglass Frames - Limited to a Maximum Benefit of $50[1]		
Flu shots and H1N1 vaccines (*administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair*)	100% - 0%	100% - 0%	100% - 0%
Hearing Aids (*Hearing Aids are not covered for individuals age eighteen (18) and older*)	90% - 10%[1,3]	70% - 30%[1,3]	80% - 20%[1,3]
Hearing Impaired Interpreter Expense	100% - 0%	100% - 0%	100% - 0%
High-Tech Imaging – Outpatient • CT Scans • MRA/MRI • Nuclear Cardiology • PET Scans	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1,2]
Home Health Care (*limit of 60 Visits per Plan Year*)	90% - 10%[1,2]	70% - 30%[1,2]	Not Covered
Hospice Care (*limit of 180 Days per Plan Year*)	80% - 20%[1,2]	70% - 30%[1,2]	Not Covered
Injections Received in a Physician's Office (*when no other health service is received*)	90% -10%[1]	70% - 30%[1]	80% - 20%[1]
Inpatient Hospital Admission, All Inpatient Hospital Services Included *Per Day Copayment* *Day Maximum* *Coinsurance*	$0 Not Applicable 90% - 10%[1,2]	$50 5 Days 70% - 30%[1,2]	$0 Not Applicable 80% - 20%[1,2]
Inpatient and Outpatient Professional Services	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Mastectomy Bras - Ortho-Mammary Surgical (*limit of three (3) per Plan Year*)	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Mental Health/Substance Abuse - Inpatient Treatment and Intensive Outpatient Programs *Per Day Copayment* *Day Maximum* *Coinsurance*	$0 Not Applicable 90% - 10%[1,2]	$50 5 Days 70% - 30%[1,2]	$0 Not Applicable 80% - 20%[1,2]
Mental Health/Substance Abuse – Office Visit and Outpatient Treatment (Other than Intensive Outpatient Programs)	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Newborn - Sick, Services Excluding Facility	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Newborn - Sick, Facility *Per Day Copayment* *Day Maximum* *Coinsurance*	$0 Not Applicable 90% - 10%[1,2]	$50 5 Days 70% - 30%[1,2]	$0 Not Applicable 80% - 20%[1,2]
Oral Surgery for Impacted Teeth	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1,2]
Pregnancy Care - Physician Services	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Preventive Care - Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (*For a complete list of benefits, refer to the Preventive and Wellness Care Article in the Benefit Plan.*)	100% - 0%[3]	70% - 30%[1,3]	Network 100% - 0[3] Non-Network 80% - 20%[1,3]
Rehabilitation Services - Outpatient: • Speech • Physical/Occupational (*Limited to 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.*) (*Visit limits do not apply when services are provided for Autism Spectrum Disorders*)	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Skilled Nursing Facility (*limit 90 days per Plan Year*)	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1,2]
Sonograms and Ultrasounds (*Outpatient*)	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Urgent Care Center	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]

	Coinsurance		
	Active Employees/ Non-Medicare Retirees (regardless of retire date)		Retirees with Medicare (regardless of retire date)
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Vision Care (Non-Routine) Exam	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
X-ray and Laboratory Services (*low-tech imaging*)	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
[1]Subject to Plan Year Deductible, if applicable [2]Pre-Authorization Required, if applicable. Not applicable for Medicare primary. [3]Age and/or Time Restrictions Apply			

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:356 (February 2015), effective March 1, 2015, amended LR 43:

§207. Prescription Drug Benefits

A. Prescription Drug Benefits

Network Pharmacy	Member Pays
Tier 1- Generic	50% up to $30
Tier 2- Preferred	50% up to $55
Tier 3- Non-preferred	65% up to $80
Tier 4- Specialty	50% up to $80
90 day supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable copayment
Co-Payment after the Out Of Pocket Amount of $1,500 Is Met	
Tier 1- Generic	$0
Tier 2- Preferred	$20
Tier 3- Non-preferred	$40
Tier 4- Specialty	$40
Prescription drug benefits-31 day refill	
Plan pays balance of eligible expenses	
Diabetic supplies are not subject to a copayment if enrolled in the In-Health/Disease Management Program.	
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug; the cost difference does not apply to the $1,500 out of pocket maximum	
Medications available over-the-counter in the same prescribed strength are not covered under the pharmacy plan.	
Smoking Cessation Medications: Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.	
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.	

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:358 (February 2015), effective March 1, 2015, amended LR 43:

Chapter 3. Narrow Network HMO Plan Structure—Magnolia Local Plan (in certain geographical areas)

§305. Schedule of Benefits

A. Benefits, Copayments, and Coinsurance

	Copayments and Coinsurance	
	Network Providers	Non-Network Providers
Physician Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics	$25 Copayment per Visit	No Coverage
Allied Health/Other Professional Visits: • Chiropractors • Federally Funded Qualified Rural • Health Clinics • Nurse Practitioners • Retail Health Clinics • Physician Assistants	$25 Copayment per Visit	No Coverage
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic	$50 Copayment per Visit	No Coverage
Ambulance Services - Ground (*for Emergency Medical Transportation only*)	$50 Copayment	$50 Copayment
Ambulance Services - Air (*for Emergency Medical Transportation only*) Non-emergency requires prior authorization[2]	$250 Copayment	No Coverage
Ambulatory Surgical Center and Outpatient Surgical Facility	$100 Copayment	No Coverage
Birth Control Devices - Insertion and Removal (*as listed in the Preventive and Wellness Article in the Benefit Plan.*)	100% - 0%	No Coverage
Cardiac Rehabilitation (*limit of 36visits per Plan Year*)	$25/$50 Copayment per day depending on Provider Type[2] $50 Copayment-Outpatient Facility[2]	No Coverage

	Copayments and Coinsurance	
	Network Providers	Non-Network Providers
Chemotherapy/Radiation Therapy (*Authorization not required when performed in Physician's office*)	Office – $25 Copayment per Visit Outpatient Facility 100% - 0%[1,2]	No Coverage
Diabetes Treatment	80% - 20%[1]	No Coverage
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	$25 Copayment	No Coverage
Dialysis	100% - 0%[1]	No Coverage
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20%[1,2] of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year	No Coverage
Emergency Room (*Facility Charge*)	$150 Copayment; Waived if admitted to the same facility	
Emergency Medical Services (*Non-Facility Charges*)	100% - 0%[1]	100% - 0%[1]
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (*purchased within six months following cataract surgery*)	Eyeglass Frames – Limited to a Maximum Benefit of $50[1]	No Coverage
Flu shots and H1N1 vaccines (*administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair*)	100% - 0%	No Coverage
Hearing Aids (*Hearing Aids are not covered for individuals age eighteen (18) and older.*)	80% - 20%[1,3]	No Coverage
Hearing Impaired Interpreter Expense	100% - 0%	No Coverage
High-Tech Imaging - Outpatient • CT Scans • MRA/MRI • Nuclear Cardiology • PET Scans	$50 Copayment[2]	No Coverage
Home Health Care (*limit of 60 Visits per Plan Year*)	100% - 0%[1,2]	No Coverage
Hospice Care (*limit of 180 Days per Plan Year*)	100% - 0%[1,2]	No Coverage
Injections Received in a Physician's Office (*when no other health service is received*)	100% - 0%[1]	No Coverage
Inpatient Hospital Admission, All Inpatient Hospital Services Included	$100 Copayment per day[2], maximum of $300 per Admission	No Coverage
Inpatient and Outpatient Professional Services for which a Copayment is Not Applicable	100% - 0%[1]	No Coverage
Mastectomy Bras (*limited to three (3) per Plan Year*)	80% - 20%[1] of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year	No Coverage
Mental Health/Substance Abuse - Inpatient Treatment and Intensive Outpatient Programs	$100 Copayment per day[2], maximum of $300 per Admission	No Coverage
Mental Health/Substance Abuse – Office Visit and Outpatient Treatment (Other than Intensive Outpatient Programs)	$25 Copayment per Visit	No Coverage
Newborn - Sick, Services excluding Facility	100% - 0%[1]	No Coverage
Newborn - Sick, Facility	$100 Copayment per day[2], maximum of $300 per Admission	No Coverage
Oral Surgery	100% - 0%[1,2]	No Coverage
Pregnancy Care - Physician Services	$90 Copayment per pregnancy	No Coverage
Preventive Care - Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (*For a complete list of benefits, refer to the Preventive and Wellness Article in the Benefit Plan.*)	100% - 0%[3]	No Coverage
Rehabilitation Services - Outpatient: • Speech • Physical/Occupational *(Limited to 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) (Visit limits do not apply when services are provided for Autism Spectrum Disorders.)*	$25 Copayment per Visit	No Coverage
Skilled Nursing Facility (*limit of 90 days per Plan Year*)	$100 Copayment per day[2], maximum of $300 per Admission	No Coverage
Sonograms and Ultrasounds (*Outpatient*)	$50 Copayment	No Coverage
Urgent Care Center	$50 Copayment	No Coverage
Vision Care (Non-Routine) Exam	$25/$50 Copayment depending on Provider Type	No Coverage
X-ray and Laboratory Services (*low-tech imaging*)	Hospital Facility 100% - 0%[1] Office or Independent Lab 100% - 0%	No Coverage

[1]Subject to Plan Year Deductible, if applicable
[2]Pre-Authorization Required, if applicable. Not applicable for Medicare primary.
[3]Age and/or Time Restrictions Apply

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:359 (February 2015), effective March 1, 2015, amended LR 43:

§307. Prescription Drug Benefits

A. Prescription Drug Benefits

Network Pharmacy	Member pays
Tier 1- Generic	50% up to $30
Tier 2- Preferred	50% up to $55
Tier 3- Non-preferred	65% up to $80
Tier 4- Specialty	50% up to $80
90 day supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable copayment
Co-Payment after the Out Of Pocket Amount of $1,500 Is Met	
Tier 1- Generic	$0
Tier 2- Preferred	$20

Tier 3- Non-preferred	$40
Tier 4- Specialty	$40
Prescription drug benefits-31 day refill	
Plan pays balance of eligible expenses	
Diabetic supplies are not subject to a copayment if enrolled in the In-Health/Disease Management Program.	
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug; the cost difference does not apply to the $1,500 out of pocket maximum	
Medications available over-the-counter in the same prescribed strength are not covered under the pharmacy plan.	
Smoking Cessation Medications: Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.	
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.	

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:360 (February 2015), effective March 1, 2015, amended LR 43:

Chapter 4. PPO/Consumer-Driven Health Plan Structure—Pelican HSA 775 Plan

§405. Schedule of Benefits

A. Benefits and Coinsurance

	Coinsurance	
	Network Providers	Non-Network Providers
Physician's Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics	80% - 20%[1]	60% - 40%[1]
Allied Health/Other Office Visits: • Chiropractors • Federally Funded Qualified Rural Health Clinics • Retail Health Clinics • Nurse Practitioners • Physician's Assistants	80% - 20%[1]	60% - 40%[1]
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic	80% - 20%[1]	60% - 40%[1]
Ambulance Services - Ground (*for Emergency Medical Transportation Only*)	80% - 20%[1]	80% - 20%[1]
Ambulance Services – Air (for Emergency Medical Transportation Only) Non-emergency requires prior authorization[2]	80% – 20%[1]	80% - 20%[1]
Ambulatory Surgical Center and Outpatient Surgical Facility	80% - 20%[1]	60% - 40%[1]
Birth Control Devices - Insertion and Removal (*as listed in the Preventive and Wellness Article in the Benefit Plan*)	100% - 0%	60% - 40%[1]
Cardiac Rehabilitation (*limited to 36 visits per Plan Year*)	80% - 20%[1,2]	60% - 40%[1,2]
Chemotherapy/Radiation Therapy (*Authorization not required when performed in Physician's office*)	80% - 20%[1,2]	60% - 40%[1,2]
Diabetes Treatment	80% - 20%[1]	60% - 40%[1]
Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities	80% - 20%[1]	Not Covered
Dialysis	80% - 20%[1]	60% - 40%[1]
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20%[1,2]	60% - 40%[1,2]
Emergency Room (*Facility Charge*)	80% - 20%[1]	80% - 20%[1]
Emergency Medical Services (*Non-Facility Charge*)	80% - 20%[1]	80% - 20%[1]
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (*purchased within six months following cataract surgery*)	Eyeglass Frames – Limited to a Maximum Benefit of $50[1]	No Coverage
Flu Shots and H1N1 vaccines (*administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair*)	100% - 0%	100% - 0%
Hearing Aids (*Hearing Aids are not covered for individuals age eighteen (18) and older*)	80% - 20%[1,3]	Not Covered
Hearing Impaired Interpreter Expense	100% - 0%	100% - 0%
High-Tech Imaging – Outpatient • CT Scans • MRA/MRI • Nuclear Cardiology • PET Scans	80% - 20%[1,2]	60% - 40%[1,2]
Home Health Care (*limit of 60 Visits per Plan Year*)	80% - 20%[1,2]	60% - 40%[1,2]
Hospice Care (*limit of 180 Days per Plan Year*)	80% - 20%[1,2]	60% - 40%[1,2]
Injections Received in a Physician's Office (*when no other health service is received*)	80% - 20%[1]	60% - 40%[1]
Inpatient Hospital Admission (*all Inpatient Hospital services included*)	80% - 20%[1,2]	60% - 40%[1,2]
Inpatient and Outpatient Professional Services	80% - 20%[1]	60% - 40%[1]
Mastectomy Bras (*limited to three (3) per Plan Year*)	80% - 20%[1]	60% - 40%[1]
Mental Health/Substance Abuse – Inpatient Treatment and Intensive Outpatient Programs	80% - 20%[1,2]	60% - 40%[1,2]
Mental Health/Substance Abuse – Office Visits and Outpatient Treatment (Other than Intensive Outpatient Programs)	80% - 20%[1]	60% - 40%[1]
Newborn – Sick, Services excluding Facility	80% - 20%[1]	60% - 40%[1]
Newborn – Sick, Facility	80% - 20%[1,2]	60% - 40%[1,2]
Oral Surgery	80% - 20%[1,2]	60% - 40%[1,2]
Pregnancy Care - Physician Services	80% - 20%[1]	60% - 40%[1]
Preventive Care - Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (*For a complete list of benefits, refer to the Preventive and Wellness/Routine*	100% - 0%[3]	100% - 0%[3]

	Coinsurance	
	Network Providers	Non-Network Providers
Care Article in the Benefit Plan.)		
Rehabilitation Services - Outpatient: • Speech • Physical/Occupational (Limited to 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) (*Visit limits do not apply when services are provided for Autism Spectrum Disorders.*)	80% - 20%[1]	60% - 40%[1]
Skilled Nursing Facility (*limit 90 Days per Plan Year*)	80% - 20%[1,2]	60% - 40%[1,2]
Sonograms and Ultrasounds - Outpatient	80% - 20%[1]	60% - 40%[1]
Urgent Care Center	80% - 20%[1]	60% - 40%[1]
Vision Care (Non-Routine) Exam	80% - 20%[1]	60% - 40%[1]
X-Ray and Laboratory Services (*low-tech imaging*)	80% - 20%[1]	60% - 40%[1]
[1]Subject to Plan Year Deductible, if applicable [2]Pre-Authorization Required, if applicable. Not applicable for Medicare primary. [3]Age and/or Time Restrictions Apply		

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:361 (February 2015), effective March 1, 2015, amended LR 43:

Chapter 5. PPO/Consumer-Driven Health Plan Structure—Pelican HRA 1000 Plan

§505. Schedule of Benefits

A. Benefits and Coinsurance

	Coinsurance	
	Network Providers	Non-Network Providers
Physician's Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics	80% - 20%[1]	60% - 40%[1]
Allied Health/Other Office Visits: • Chiropractors • Federally Funded Qualified Rural Health Clinics • Retail Health Clinics • Nurse Practitioners • Physician's Assistants	80% - 20%[1]	60% - 40%[1]
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic	80% - 20%[1]	60% - 40%[1]
Ambulance Services - Ground (*for Emergency Medical Transportation Only*)	80% - 20%[1]	80% - 20%[1]
Ambulance Services – Air (for Emergency Medical Transportation only)	80% - 20%[1]	80% - 20%[1]
Non-emergency requires prior authorization[2]		
Ambulatory Surgical Center and Outpatient Surgical Facility	80% - 20%[1]	60% - 40%[1]
Birth Control Devices - Insertion and Removal (*as listed in the Preventive and Wellness Article in the Benefit Plan*)	100% - 0%	60% - 40%[1]
Cardiac Rehabilitation (*limited to 36 visits per Plan Year*)	80% - 20%[1,2]	60% - 40%[1,2]
Chemotherapy/Radiation Therapy (*Authorization not required when performed in Physician's office*)	80% - 20%[1,2]	60% - 40%[1,2]
Diabetes Treatment	80% - 20%[1]	60% - 40%[1]
Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities	80% - 20%[1]	Not Covered
Dialysis	80% - 20%[1]	60% - 40%[1]
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20%[1,2]	60% - 40%[1,2]
Emergency Room (*Facility Charge*)	80% - 20%[1]	80% - 20%[1]
Emergency Medical Services (*Non-Facility Charge*)	80% - 20%[1]	80% - 20%[1]
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (*purchased within six months following cataract surgery*)	Eyeglass Frames – Limited to a Maximum Benefit of $50[1]	No Coverage
Flu Shots and H1N1 vaccines (*administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair*)	100% - 0%	100% - 0%
Hearing Aids (*Hearing Aids are not covered for individuals age eighteen (18) and older*)	80% - 20%[1,3]	Not Covered
Hearing Impaired Interpreter Expense	100%-0%	100%-0%
High-Tech Imaging - Outpatient • CT Scans • MRA/MRI • Nuclear Cardiology • PET Scans	80% - 20%[1,2]	60% - 40%[1,2]
Home Health Care (*limit of 60 Visits per Plan Year*)	80% - 20%[1,2]	60% - 40%[1,2]
Hospice Care (*limit of 180 Days per Plan Year*)	80% - 20%[1,2]	60% - 40%[1,2]
Injections Received in a Physician's Office (*when no other health service is received*)	80% - 20%[1]	60% - 40%[1]
Inpatient Hospital Admission (*all Inpatient Hospital services included*)	80% - 20%[1,2]	60% - 40%[1,2]
Inpatient and Outpatient Professional Services	80% - 20%[1]	60% - 40%[1]
Mastectomy Bras (*limited to three (3) per Plan Year*)	80% - 20%[1]	60% - 40%[1]
Mental Health/Substance Abuse - Inpatient Treatment and Intensive Outpatient Programs	80% - 20%[1,2]	60% - 40%[1,2]
Mental Health/Substance Abuse – Office Visit and Outpatient Treatment (Other than Intensive Outpatient Programs)	80% - 20%[1]	60% - 40%[1]
Newborn - Sick, Services excluding Facility	80% - 20%[1]	60% - 40%[1]
Newborn - Sick, Facility	80% - 20%[1,2]	60% - 40%[1,2]
Oral Surgery	80% - 20%[1,2]	60% - 40%[1,2]
Pregnancy Care - Physician Services	80% - 20%[1]	60% - 40%[1]
Preventive Care - Services include	100% -	100% -

	Coinsurance	
	Network Providers	Non-Network Providers
screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (*For a complete list of benefits, refer to the Preventive and Wellness/Routine Care Article in the Benefit Plan.*)	0%[3]	0%[3]
Rehabilitation Services - Outpatient: • Speech • Physical/Occupational (*Limited to 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.*) (*Visit limits do not apply when services are provided for Autism Spectrum Disorders.*)	80% - 20%[1]	60% - 40%[1]
Skilled Nursing Facility (*limit 90 Days per Plan Year*)	80% - 20%[1,2]	60% - 40%[1,2]
Sonograms and Ultrasounds - Outpatient	80% - 20%[1]	60% - 40%[1]
Urgent Care Center	80% - 20%[1]	60% - 40%[1]
Vision Care (Non-Routine) Exam	80% - 20%[1]	60% - 40%[1]
X-Ray and Laboratory Services (*low-tech imaging*)	80% - 20%[1]	60% - 40%[1]
[1]Subject to Plan Year Deductible, if applicable [2]Pre-Authorization Required, if applicable. Not applicable for Medicare primary. [3]Age and/or Time Restrictions Apply		

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:364 (February 2015), effective March 1, 2015, amended LR 43:

§507. Prescription Drug Benefits

A. Prescription Drug Benefits

Network Pharmacy	Member pays
Tier 1- Generic	50% up to $30
Tier 2- Preferred	50% up to $55
Tier 3- Non-preferred	65% up to $80
Tier 4- Specialty	50% up to $80
90 day supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable co-payment
Co-Payment after the Out Of Pocket Amount of $1,500 Is Met	
Tier 1- Generic	$0
Tier 2- Preferred	$20
Tier 3- Non-preferred	$40
Tier 4- Specialty	$40
Prescription drug benefits-31 day refill	
Maintenance drugs: not subject to deductible; subject to applicable copayments above.	
Plan pays balance of eligible expenses	
Diabetic supplies are not subject to a copayment if enrolled in the In-Health/Disease Management Program.	
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug; the cost difference does not apply to the $1,500 out of pocket maximum	
Medications available over-the-counter in the same prescribed strength are not covered under the pharmacy plan.	
Smoking Cessation Medications: Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.	
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.	

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:365 (February 2015), effective March 1, 2015.

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:341 (February 2015), effective March 1, 2015, amended LR 43:

Public Hearing

In accordance with La. R.S. 49:968(H)(2), the Office of Group Benefits will facilitate a public hearing on these proposed substantive changes on August 30, 2017, at 10 a.m. in the Louisiana Purchase Room, located on the first floor of the Claiborne Building, located at 1201 N. Third Street, Baton Rouge LA 70802.

Tommy Teague
Chief Executive Office